| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 012007 | A. BUILDING: _____ B. WING _____ | C 12/22/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVER CROSSING ASSISTED LIVING | 2400 MARKET ST CHARLESTOWN, IN 47111 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R 000 | INITIAL COMMENTS<br><br>INITIAL COMMENTS:<br><br>This visit was for the Investigation of Complaint IN00160751.<br><br>Complaint IN00160751- Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey date: December 22, 2014<br><br>Facility number: 012007<br>Provider number: 012007<br>AIM number: N/A<br><br>Survey team:<br>Trudy Lytle, RN-TC<br><br>Census bed type:<br>Residential: 100<br>Total: 100<br><br>Census payor type:<br>Medicaid: 81<br>Private: 22<br>Total: 103<br><br>River Crossing Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00160751.<br><br>Quality Review 12/23/14 by Lisa McColly | R 000 | | |